

Men, Masculinities and Male Cancer Awareness: a preliminary study

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1. Introduction

1.1 Aim and Research Questions

The aim of this small-scale project is to explore Scottish men's awareness of 'male cancer' specifically and to examine the relationship between the lived experience of masculinities and the meanings that men attribute to health, well being, health care providers and services and male cancer. The data presented here are analysed and discussed with a view to informing future, larger-scale investigations into barriers to cancer screening service use and the consumption of public health messages related to male cancers amongst men, as well as the development of user-driven sources of information on male cancers and cancer screening awareness campaigns that recognise the diversity of Scottish men's identities and experiences. Data were generated from four focus group meetings with a diversity of men from across Scotland, focussing on areas of particularly high incidences of male cancers specifically, and poor health records generally (Glasgow, Edinburgh and West Dunbartonshire).

More specifically, the research addresses the following questions:

- What does being a man living in Scotland mean to participants?
- What do Scottish men understand 'male cancer' to mean?
- Does being a man impact on awareness of specific cancers, cancer risks and cancer screening services?
- What are the most effective means of raising men's awareness of male cancers?

1.2 Cancer in Scotland

The likelihood of people living in Scotland developing a cancer at some point during their lifetime is high, according to the NHS Cancer in Scotland Report (2010). Indeed, it is possible to identify the three most prevalent forms of cancer amongst men and women living

in Scotland. According to the NHS (*ibid*: 9) amongst men in Scotland, 1 in 13 are at risk of developing lung cancer, 1 in 12 are at risk of developing prostate cancer and one in 18 are at risk of developing colorectal cancer over a lifetime. Furthermore, amongst women in Scotland, 1 in 10 are at risk of developing breast cancer, 1 in 16 are at risk of developing lung cancer and 1 in 22 are at risk of developing colorectal cancer. Overall, 2.4% of men and 3.2% of women in Scotland are currently living with cancer (2,352 and 3,186 per 100,000 population).

With advances in detection and treatment, the probability of surviving cancer is improving. For people who were diagnosed with any form of cancer in the period 2003-2007 in Scotland, 59% of men and 66% of women survived to one year following actual diagnosis, whilst 36% of men and 45% of women survived to five years following actual diagnosis (*ibid*, 2010: 17)

The five-year survival rate for cancer patients, increased from 26% for men diagnosed in 1983-1987 to 44% for men diagnosed in 2003-2007, and from 36% to 51% for women in the same periods (*ibid*, 2010: 17).

There are three cancers which affect men specifically: prostate, testicular and penile cancer. Over 35,000 men in the UK are diagnosed with prostate cancer every year. It is the most common cancer in men over the age of 55. Survival from prostate cancer has improved substantially in that time period, from 56% to 85%. Testicular cancer is the most common cancer in younger men aged between 15 and 45, and the rate is increasing. There are nearly 2,000 cases per year, but it is relatively rare compared to cancers such as lung or breast cancer. More than 95% of patients are cured by chemotherapy. Cancer of the penis is extremely rare in the Western world and it is most often diagnosed in men over the age of 60, though it may occur in younger men too. It is estimated that there are about 400 cases in the UK every year (Orchid: Fighting Male Cancer, 2010).

2. Literature Review: Men, Masculinities and Cancer

There is a growing body of research which exposes the social expectations of masculinity as a hindrance to men making best use of health care provision (Lanz et. al, 2001; Maliska et.al. 2008; Naymark, 2006), as well as a developing field of knowledge exploring men's experiences of cancer and cancer screening (Chapple, et.al. 2008; Dubé et.al. 2004; Hilton, et.al, 2009; Oliffe & Bottorff, 2007). However, there is a poverty of research that explores the relationship between men's conceptualisations of masculinities and their knowledge and perceptions of male cancers specifically, particularly within the context of Scotland.

There is evidence that men differ significantly from women, in terms of men being less likely to access health information and health services and more likely than women to feel uneasy in health care settings (Dubé et.al. 2004). In this context then, it is unsurprising that men are less likely than women to make full use of cancer screening services. For example, Vart's (2010) research into potential barriers to bowel cancer screening revealed that, amongst the 80 male participants who completed a short questionnaire, a significant majority indicated that they were unlikely to participate in bowel cancer screening, largely because men were less fearful about bowel cancer - perhaps because men were less knowledgeable about the implications of a bowel cancer diagnosis - than women (*ibid.*: 245) and more fatalistic than women (*ibid.* 246).

In their analysis of data from Cancer Research UK and the UK National Cancer Intelligence Network, White et.al (2010) concluded that men are more likely to be diagnosed and to die from those cancers which should affect men and women equally. Whilst they argue that there is insufficient evidence to explain precisely why men are more at risk than women (*ibid.* 469) and they suggest that it is not possible to assert with absolute certainty that men are delaying attending for medical treatment or screening, what is clear is that men are not outstripping women in terms of medical consultations generally, in spite of the greater risks

of developing some cancers amongst men (*ibid*: 469). White et.al conclude with a call to raise awareness of cancer risks and screening services amongst men, and for health professionals to adopt a more aggressive approach to advocating treatment, earlier, for men.

Indeed, there is a poverty of research into the information-seeking behaviours of men in relation to health, especially those who have recently been diagnosed with cancer (McCaughan & McKenna, 2007). However, there is evidence that men who are newly diagnosed with cancer will often rely on women partners to seek out information sources and support on their behalf, because men are more likely to feel uneasy in health care settings, and less likely to consult a range of sources of information, when compared to women (*ibid.*). However, in contradistinction to this, in their secondary analysis of interviews conducted with 19 Canadian and 33 Australian prostate cancer survivors, Oliffe & Thorne (2007) identified a willingness amongst participants to engage in self-motivated research into prostate cancer, accessing the internet, cancer agencies and the experiences of survivors (*ibid.*: 159). These strategies enabled patients to employ biomedical language during their consultations with predominantly male cancer specialists. In a related fashion, proactive strategies for accessing social and information networks improved knowledge of the implications of a prostate cancer diagnosis in Zanchetta et.al's (2007) modélisation qualitative research study into the experiences of 15 men aged 61 – 83 in Québec, Canada. In other words, the more informed men are, the more 'positive' their experience of a cancer diagnosis will be.

Even when men do consult health professionals, and are diagnosed with cancer, men are still more likely than women to keep their diagnosis secret (Hilton, et.al. 2009). Drawing on data generated from narrative interviews with 37 participants in Scotland, Hilton et.al (2009) argue that some men reported being worried about being perceived differently by their peers, since admitting to having fears about health generally, and cancers specifically, was considered an emasculating experience. Furthermore, men were more likely than women to employ humour as a vehicle to deflect attention from the embarrassment of a very serious situation when discussing their cancer with male friends or colleagues (*ibid.*: 751). The

mobilisation of humour amongst men as a mechanism for challenging assumptions about cancer was also identified in Chapple & Ziebland's (2004) study of 45 men who had been diagnosed with testicular cancer. Their analysis of the data generated from qualitative interviews, revealed that men often employed humour to help them 'deal' with having testicular cancer, in personal relationships to challenge other people's assumptions about their cancer, as well as in health settings in order to offset their feelings of anxiety or embarrassment (*ibid.*: 1127).

The younger men in Hilton et.al's (2009) study were particularly concerned about feeling excluded, or being given special treatment by their peer group as a result of their cancer diagnosis (*ibid.*: 752). This 'stoicism' is symptomatic of the well documented pressures associated with the socially constructed ideals surrounding the performance of hegemonic masculine identities (Connell 2005). In hegemonic masculinity, we see an emphasis on the social power of men and the embodiment of masculinity in terms of strength and self-reliance which, it has been argued, has a detrimental effect on the likelihood of men seeking help in relation to their health (Galdas, 2009).

In this context, then, there is certainly evidence to suggest that men are often resistant to, or feel uncomfortable talking about cancers, let alone presenting for cancer screening or consulting health professionals. Indeed, the experience of prostate cancer, the process by which it is investigated, the idea of a prostatectomy and the way in which it is understood have been informed by an essentialist conception of gender roles, not least in terms of hegemonic masculinity as the archetypal image to which men should adhere (Wall & Kirstjanson. 2005). There is uncertainty surrounding the accuracy of the prostate specific antigen (PSA) test, which is used regularly to screen men for prostate cancer in the United Kingdom (Chapple et. al 2008), and this uncertainty may yet further undermine the emphasis on self-control, self-regulation and self-reliance which is invoked by the social requirements of hegemonic masculinity.

Yet, is the compulsion to operate within the strictures of hegemonic masculinity the experience of all men, at all times? In their critical review of constructions of masculinity in qualitative prostate cancer research, Wall & Kristjanson (2005) rightly question whether the rigidity of the frame of reference within which hegemonic masculinity finds its expression is sophisticated enough to convey the complexity of the diversity of men's actual experiences and, indeed, the ways in which different men may make sense of a diagnosis of prostate cancer and, subsequently, engage with their treatment programmes. An over-concentration on a static conception of hegemonic masculinity runs the risk of under-playing the complexity and diversity of what it actually *means* to be a man and the resultant impact that such diversity may have on attitudes to, knowledge and experiences of cancer.

This is a message that is not lost in the work of Oliffe & Bottorff (2007) in Canada. Their research with 19 prostate cancer survivors employed the innovative method of photo-elicitation. Here, participants were asked to take photographs of objects, people, places, and spaces which visually expressed their experiences of prostate cancer and which, in subsequent interviews, would be employed as prompts to help participants explore their experiences with the researchers. Oliffe & Bottorff (2007: 857) confront the myths and the taboos surrounding the cultural restrictions associated with men's *perceived* inability to open up about their health generally and cancer specifically. On the contrary, the richness and complexity of the data which reflect the participants' experiences of illness are crucial, they argue, in terms of developing interventions that recognise the lived realities of a cancer diagnosis and treatment for men.

The willingness of the male participants to engage with the photo-elicitation process raises questions over the validity of the over-generalised conception that men, as a social group, are unwilling to talk about their experiences of cancer; indeed, when men are given the opportunity to explain their experiences of cancer from within their own cultural environs, they are certainly willing to talk. Such an emphasis on the cultural relativity and contested nature of the experience of masculinities was central to Maliski et.al's (2008) research

exploring the experiences of prostate cancer treatment amongst low-income Latino and African American men in California. Their central thesis is that constructions of masculinity amongst the participants are multi-dimensional and constantly in flux and, indeed, each individual's enactment of masculinity is very much informed by their early life experiences (*ibid.*: 1614). However, whilst there were some traits which all participants considered central to being a man, not least an emphasis on independence, control and physical and emotional fortitude, there were also significant differences between the African American and Latino participants. Specifically, African American men tended to articulate being a man as being a matter of individual style, with no particular 'set definition' (*ibid.*: 1613), whereas Latino men tended to offer a more relational and, indeed, physical definition of masculinity, in terms of men's role in protecting their wives and family, maintaining a stable job and an emphasis on physical strength. In spite of the differences, the diagnosis and experience of prostate cancer, the treatment process, the side effects - including incontinence - and the road to recovery, challenged each of the participants' sense of (masculine) self. There was evidence that the experience of having prostate cancer and surviving meant that the men were engaged in a process of reconstructing their masculine identities through a process of renegotiation following prostate cancer (*ibid.*: 1618).

This renegotiation process was also highlighted in Wall & Kristjanson's (2005) study, in which some men were able to normalise and frame their erectile dysfunction as an expected offshoot of cancer treatment and, therefore, a regular part of their renewed, reformulated sense of masculinity post-cancer treatment. Similarly, narratives of a new attitude to the male body, a new outlook on life and changed priorities after cancer permeate the narratives of participants in Kelly's (2009) ethnographic study examining the experiences of prostate cancer, its side effects and treatment amongst 14 men.

This particular study is designed to augment the current body of knowledge, with a specific focus on examining how different groups of men articulate what it means to be a man living in Scotland, which has a high incidence of cancers amongst men, and how their identities

impact upon men's attitudes to health, well-being and health care providers generally, and their attitudes to, knowledge and perceptions of male cancers specifically.

Accordingly, this research has been designed to unpack the meaning of masculinities and their impact on awareness of male cancers. Cahonas Scotland will use the knowledge generated to inform policy makers, public health and medical practitioners and those working in cancer support services about the complexities of the relationship between masculinities and attitudes to and awareness of male cancers, as well as providing a forum for men to share with each other their knowledge, understanding, experiences and fears surrounding male cancer.

3. Research Design

3.1 Interpretivism

This research is embedded within an interpretivist, qualitative paradigm. The qualitative research paradigm is an investigative process which enables researchers to progressively make sense of the social issue in question by contrasting, comparing, replicating, cataloguing and classifying the subjective experiences of human participants (Miles & Huberman, 2002). In this specific case, the researcher is drawn to making sense of the overlapping realities and novel ways of knowing about male cancer which are firmly embedded within the subjective experiences of a range of men living in Scotland. Indeed, as Creswell states (1994: 5): "The qualitative researcher needs to report faithfully these realities and to rely on the voices and interpretations of informants."

3.2 Focus Groups

In order to reach the 'voices and interpretations of' participants, focus groups were employed in order to elicit rich verbal, linguistic data. By their very nature, focus groups are interactive encounters and, when participants hear about the experiences and perceptions of other

members of the group, they are likely to be motivated to expand on and refine their own ideas and perceptions about the topic. Indeed, focus groups are ideal for eliciting shared group understanding and norms (Barbour & Kitzinger, 1996). Each person's comments, therefore, encourage further responses from other participants by; evoking ideas in other respondents; prompting individuals to recall things they may have forgotten; and, through collaborative knowledge building, enable participants to express their opinions more clearly (Davis, 1997: 200, in Daymon, 2002). In this context, the realities of individual participants are intersubjective (Berger & Luckman, 1997), which means that each person's meanings relate to, and to some extent depend on, the meanings of others.

In preparation for qualitative techniques of data collection, Lofland and Lofland (1995: 78) urge researchers to reflect on the following question: "Just what is it about this thing (that) is puzzling me?". Accordingly, the focus group guide (see Appendix 1) was constructed by developing a series of "puzzlements", which were subsequently organised into thematic "piles of paper" (*ibid.*: 79) and, with time, an ordered and structured sequence of topics and questions for discussion during the focus groups emerged. Three main topics for discussion were identified, namely; identities, health and cancer awareness.

To further enhance the depth and quality of discussions within the focus groups, vignettes were employed. Vignettes can serve many functions in qualitative research: to illuminate people's attitudes, experiences and perceptions of specific phenomena; and, most crucially, to provide a less threatening, depersonalised mechanism for exploring potentially sensitive topics (Spalding & Phillips, 2007). In qualitative research, vignettes enable participants to define a situation or channel their own opinion about a specific problem, without necessarily attributing opinion to their own experiences (Brondani, et.al. 2008; Oliffe & Bortoff 2007). Given the potential challenges and sensitivities involved in inviting men to talk about health and well being generally, and male cancers specifically, vignettes proved ideal mechanisms for engendering a sense of ease amongst participants, as well as enhancing the quality of discussions.

The first vignette case study (see appendix 1) was based upon the experiences of 'Patrick', one of the participants in Oliffe & Borttoff's (2007) photo-elicitation study into the experiences of 19 prostate cancer survivors. Participants were shown a photograph which Patrick had taken during the research process, in which, from the chest down, a virtually naked male figure (Patrick) can be seen wearing an absorbent urine pad. The photograph was accompanied by an extract of Patrick's narrative on his experiences of living with, and surviving, prostate cancer. Participants were subsequently asked a number of questions about the vignette, including: how effective is this photograph for telling us about how Patrick feels following his surgery for prostate cancer?; what do you think men would make of Patrick's photograph and story?; do you think that men would feel sympathy for Patrick?; and, do you think that men would consider Patrick to be brave to tell his story in this way?.

Given the centrality of football to 'lad's culture' and 'masculinity' (Pringle, 2004: 123), particularly in Scotland, the second vignette was based upon a recording of a television interview with John Hartson, a former Glasgow Celtic football player (see Appendix 1). Hartson's struggle with testicular cancer was well publicised and, in the recording, he can be heard warning men not to ignore the signs of testicular cancer, as he had done. Once participants had watched the recording, they were asked to reflect on a number of questions, including: how would you describe John Hartson?; why do you think he might have ignored the signs of cancer?; and, how do you think men in Scotland reacted when they heard that John Hartson had cancer?.

3.3 Data Analysis

With the express aim of hearing 'the voices and interpretations of' participants (Creswell, 1994: 5), it was essential to allow the data generated from the focus groups to speak for themselves as far as possible. Therefore, it was crucial to avoid the imposition of prior 'theoretical interests' and researcher assumptions upon the data, in order to prioritise the subjective, phenomenological realities of participants (Braun & Clarke, 2006). Data were,

therefore, organised and interpreted by employing inductive thematic analysis (Boyatzis, 1998). Thematic analysis is “an accessible and theoretically flexible approach to analysing qualitative data” (Braun & Clarke, 2006: 77), in which the themes generated are firmly embedded within the original context, meaning and spirit of participants’ talk. A theme is a recurring patterns of talk characterised by a unifying meaning; words, phrases, sentences or collections of sentences that emerge out of the data, which not only *describe* participants’ stories of being men living in Scotland, of their attitudes to health and well being, or their knowledge and understanding of male cancers, but which also *interpret* participants’ attitudes, experiences and opinions (Boyatzis, 1998).

3.4 Data Storage

Focus groups were recorded using an audio dictaphone. All data were anonymised at all times. Once the recordings were transcribed, data were stored electronically, and password protected. Paper copies of transcriptions were kept under lock and key. All data will be destroyed no later than five years following the end of the funding period. Signed consent forms (Appendix 3) will be stored separately from the data for 12 months on the University campus and thereafter in remote secure storage for the duration of the retention of the physical data.

3.5 Participant Inclusion Criteria and Recruitment

The demographic of participants in the four focus groups in the study was designed to enable the generation of data from a relatively diverse cross-section of men in the central belt of Scotland. Particular care has been taken to include groups who are especially susceptible to male cancers (for example, men over 40 years old) (NHS, 2010), men who may experience poor health generally (for example, homeless men) (Stein, et.al., 2009), men who may experience culturally-specific barriers to accessing health care services and internalising public health campaigns and messages (for example, younger men, minority ethnic men and homeless men) (Furlong et.al, 2003; Campbell and McLean, 2003; Stein

et.al., 2009); and geographical areas with documented poor levels of health generally (for example, Glasgow and West Dunbartonshire) (*Information Services Division, NHS National Services Scotland, 2010*).

With all of this in mind, there were clear inclusion criteria for each of the focus groups:

Location	Participants
Glasgow	Minority ethnic men (Pakistani Heritage)
Edinburgh	Over 40 years old men
Clydebank	18 – 25 years old men
Glasgow	Homeless men

Participants were recruited from community volunteer groups, an emergency services organisation and a Further Education College, with the assistance of staff from West Dunbartonshire CVS (<http://www.wdcvs.com/>). West Dunbartonshire CVS (WDCVS) offers a community and volunteering sector interface designed to represent, advise, support and develop all levels of voluntary and community activity across West Dunbartonshire specifically, and in other areas of Scotland.

Purposive sampling refers to sampling with a specific focus in mind (Punch, 2005). Because the project aims specifically to elicit the views of men from different groups living in Scotland, purposive sampling techniques have been employed with the clear inclusion criteria detailed above. Two of the focus groups participants were, therefore, recruited through contacts in voluntary organisations working with minority ethnic men and homeless men in Glasgow. Furthermore, a Further Education College in West Dunbartonshire helped with the recruitment of men between 18 and 25, and an emergency service organisation in Edinburgh assisted with the recruitment of men over 40.

Recruiting participants through organisations which currently have fruitful working relationships with WDCVS and the research team has engendered a real sense of trust amongst participants, as well as a reliable conduit between the researcher and participants.

3.6 Ethical Issues

Undertaking sound social science research requires an awareness of, and sensitivity to, potential ethical issues by researchers. Indeed, the researcher must always ensure that strategies are in place to ensure that participants come to no physical or psychological harm, are not deceived in any way, have the right to privacy and anonymity and understand why they are involved in the research.

Explicit informed written and verbal consent were obtained from all participants. Prior to the commencement of each focus group, participants were provided with an Information Sheet (Appendix 2), detailing the purpose of the research in general, and the focus group specifically. In addition, participants were each provided with a Consent Form (Appendix 3), which they were asked to sign to confirm that they were content to participate in the study. Throughout the project, all participants were informed of their right to withdraw from the research at any point, without explanation.

In recognition of the potential sensitivities surrounding the discussion of participants' awareness of male cancers, debriefing information was available for all groups, including key sources of support, routes to advice and information about male cancer specifically. Examples include:

- The John Hartson Foundation: <http://www.johnhartsonfoundation.com/>
- Orchid – Fighting Male Cancers: <http://www.orchid-cancer.org.uk/>
- McMillan Cancer Support: <http://www.macmillan.org.uk/Home.aspx>
- Cancer Research UK: <http://www.cancerresearchuk.org/>
- Healthtalkonline: www.healthtalkonline.org
- Male Cancer Awareness Campaign: <http://www.malecancer.org/>

With the express permission of participants, focus groups were recorded and transcribed verbatim. In order to maximise participant anonymity, each participant was given a pseudonym on the transcript and all hard copies of data are kept under lock and key, whilst

electronic data are password protected. All data collected will be handled in line with current Data Protection legislation and the confidentiality of participants will be maintained at all times.

Here is an overview of the participants in each of the focus groups:

Glasgow – Homeless men	Edinburgh – Men over 40 years old	Glasgow – Minority Ethnic Men	Clydebank – 18 – 25 year old men
Kevin	Tim	Tariq	Iain
John	Colin	Mo	David
Francis	Jim	Anwar	Michael
Ben	Simon	Yousuff	Paul
Liam	Larry	Bashir	Terry
Neil	Edward	Naveed	Clive
Tony	Andy	Rageh	Nicolas
Victor	Noel	Imran	Brian
William	Malcolm	Usama	Ryan
Ronald		Salim	
Arnold			
Conor			

It is recognised that the group of homeless men are an especially vulnerable group (Stein et al, 2009) and we were, therefore, mindful that great care must be taken to ensure that participants were fully able to exercise their free will in giving their consent to participate, without fear of coercion or undue persuasion. With this in mind, we worked in conjunction with a Glasgow-based charity which provides practical, residential housing support for young homeless adults. The Board of the charity were extremely keen to offer their residents the opportunity to participate in the project, and provided their explicit consent to use the Project's facilities and support services throughout the recruitment, data collection and debriefing stages of the research.

Information about the research project was disseminated to residents through the organisation via posters and word-of-mouth from keyworkers. Any resident who was interested in taking part in the project was encouraged to discuss their motivations for, and potential benefits of participating, with their keyworker in the first instance. Contact details for the researcher and the Chairperson of Cahonas Scotland were detailed on the information sheet (Appendix 2) and potential participants were free to contact us for further details. The young people on the project have the support of an individual keyworker who, in turn, is supported by a co-worker. The participants' keyworker was on hand to lend support before, during and after the focus group, in the event that any participant should become distressed in any way. Following advice from the charity Board members, the focus group took place in the early afternoon to ensure that participants have had the opportunity to relax into the day, for staff to ensure that potential participants are in a positive frame of mind, that they had the opportunity to ask more questions about the focus group in advance, as well as having the space and time to reflect on their experience of the focus groups with each other and their support workers afterwards.

3.7 Contributions to Knowledge

All qualitative research has ethical risks. However, the minimal ethical risks associated with this research in particular are outweighed when we consider the ways in which the data generated will contribute to knowledge of Scottish men's understanding of male cancers.

The research can be justified in the following contexts:

- There is a lack of detailed qualitative data on the relationship between men, masculinities, health and well being and awareness of male cancers in Scotland specifically.
- There is a lack of research which examines the perceptions of male cancers amongst *diverse* groups of men in Scotland.

- There is a lack of research into men's perceptions generally of the most effective means of raising awareness about male cancers amongst men specifically.

4. Results and Discussion

Five major themes emerged from the process of inductive thematic analysis:

- *'Real' Scottish Men*: Participants highlighted the central characteristics of masculinity in Scottish men, particularly emphasising stereotypical notions of poor health, alcohol and drug dependency, physical and emotional fortitude and a strong desire to protect others.
- *Culture and Expectations*: Participants stressed the importance of recognising cultural context in conceptualising what it means to be a man living in Scotland, painting a picture of Scottish masculinity as one that is contested, constantly in flux and shifting. The influence of peers, familial responsibilities and expectations, national pride and identity, as well as age and maturity were particularly highlighted as essential elements in explaining what it means to be a man living in Scotland.
- *Conceptualising Health and Male Cancer*: Participants had a broad range of attitudes to, perceptions of and experiences of health, health care and male cancer specifically. Key factors highlighted by participants as influential to the ways in which they considered health included degree of trust in the attitudes and knowledge of health professionals; strategies for accessing health information; knowledge about male cancers, risk behaviours and fear of the unknown; emphasising positive stories; men's propensity to ignore the signs of ill health and male cancer; and, the power of visual representations of the effects of cancer.
- *Humour*: Participants often employed humour as a vehicle for deflecting attention from their anxieties and embarrassment about health issues.
- *The Power of Personal Narratives*: Participants reacted positively to the real-world experiences of men who had been diagnosed with and survived cancer. When confronted with the personal narratives of cancer survivors, in parallel with visual

representations of their experiences, participants demonstrated a willingness and desire to share their personal impressions of the story with each other, often relating the experiences of the central figure in the story to their own attitudes and experiences.

In the presentation of the data, participants' pseudonyms will be followed by a number – for example, Ben (1) – to denote the focus group from which the extract is derived. The focus groups are categorised thus:

- (1) Young homeless men.
- (2) Men over 40.
- (3) Minority ethnic men.
- (4) 18 – 25 year old men.

4.1 'Real' Scottish Men

Participants' descriptions of the essential ingredients of being a 'real' Scottish man closely aligned with many of the central characteristics of hegemonic constructions of masculinity (Connell, 2005; Galdas 2009), with an emphasis on strength and physical aggression, a lack of emotional literacy and a resistance to take their own health and well being seriously.

'Physicality'

Scottish men were conceptualised in terms of a hard physicality by some participants:

Tim (2): Quite hard I suppose...em...that's a stereotypical view. Hard working, hard playing...

As well as physical strength being manifested in both the work and leisure aspects of Scottish men's lives, some participants emphasised the propensity to violence amongst some Scottish men:

Ben (1): No way man. It's always been violence on violence, nah whit a mean? If av goat a problem, ad be like that, fuck it ..(gestures with clenched fist)...., nah whit a mean?

This focus on the relational dimensions of physicality and violence in conceptions of Scottish masculinity was especially echoed by participants in the 18 -25 year old focus group:

Iain (4): In Clydebank ad say that if you look mean and know how tae throw yer weight aboot then, no everybody obviously, but a lot of people, wid hink, aye, he's a man's man.

David (4): Am not gonnae be put down by anyone sayin anything and, to me, being a man is, you know, not letting anyone or anything stand in the way of whatever it is that you're aiming on doin, whether it is verbal, physical, it doesn't matter; it's just standing up for yourself and not being brought down by anything or anyone that wants to bring you down for it.

The emphasis on violence as a key element of physical fortitude in masculinities was further emphasised by Bashir, when reflecting on the perception of young Asian men in Glasgow:

Bashir (3): There's Asian boys in Glasgow....em....you know. They get a bad press. They're out there causing trouble, some of them, and getting intae fights and stuff. And the press make a big deal of the fact that they're Asian too. But it's cos they've got nothing to do around here really.

Whilst Bashir is keen to emphasise the ways in which a broader lack of opportunities might explain a propensity towards violence in the enactment of masculinity in some men, David was particularly concerned about the ways in which the relationship between alcohol and violence had become central to the stereotypical conception of Scottish men, and about the impact that this might have on people's perceptions of himself and the people close to him:

David (4): Well, like alcoholics and violence and...you know...not safe to be around and everything and, it's not like everyone. I know a large number of people in this room and in my area and work, everywhere, and they're all good people, they're all good friendly people and they're getting stereotyped cos of these small groups.

Here, David is rejecting the equation of the enactment of masculinity with physical violence, drawing attention to the fact that the violent displays of masculinity by some men had significant consequences for the way in which the majority of men were conceived. Indeed,

as Segal (199) has previously indicated in her seminal work on the completing forces which generate multi-faceted expressions of masculinity in different times and places, violent displays of hegemonic masculinity have often been bought at a cost to men themselves. As David highlights, not all men choose to adhere to the strictures of hegemonic masculinity (Wall and Kristjanson, 2005).

For some participants in the over 40 focus group, the emphasis on violence as integral to the culture of Scottish masculinity was waning:

Simon (2): I think there's now an effort to subvert that sort of stereotype with the media and, you know, this concept....I hate the terminology...but this sort of new man, you know, getting in touch with your inside and, you often, you would never have seen, for example, maybe images of men holding babies, say twenty or thirty years ago...that sort of thing.

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'Emotional Literacy'

There was a common conception amongst participants, that there were high levels of mental health difficulties amongst Scottish men:

Michael (4): But mental health is higher in men in general. The suicide rate is higher in men than it is in women.

Such awareness was articulated in the context of an overarching impression amongst participants of an apparent unease, amongst Scottish men in general, to open up about their feelings. When asked about how comfortable they felt about talking about their emotions and feelings, some participants indicated a real sense of resistance to 'opening up', with the young men in the homeless group and the 18-25 group particularly highlighting how men will often rely on alcohol to either help them talk about, or indeed avoid, issues that are concerning them:

Neil (1): Just bottle it up, know what ah mean, fuck that man. But, I suppose, it's like a relief, man, if you were able tae talk tae somebody about stuff.

Ben (1): It's only if yer mad wae it or pished that ye can talk about hings, innit?... (all laugh)... A mean, ye always get pure get the chat when yer talkin tae yer pals and yer full o it, wance you've goat a drink. That's it innit?

However, whilst Neil and Ben describe the consumption of alcohol as a liberating experience in terms of being able to open up about their feelings, some of the participants in the 18 – 25 year old focus group relate the culture of consuming alcohol amongst men as a mechanism for evading openly expressing their emotions:

Michael (4) It's being a guy, like if ye were tae go in a room and ye were aw sitting hivin a drink, and huvin a laugh an that, an yer pal started greeting and getting aw emotional. Ye'd aw turn aroon an be like that, aw uncomfortable, know whit a mean? Ye'd be like that c'moan boys, know whit a mean? If it's a guy, yer like 'aw, av no goat feelings, av no goat emotions'. You sit in the corner, cos we're huvin a party.

David (4): ...your problem's your problem, mine is mine. Leave it at that, have a pint, there you go! That's' basically how they would see it, you know

Furthermore, some participants did indicate that the relationship between 'being hard' and alcohol consumption still persisted amongst older Scottish men, and was not isolated to younger men's experiences:

David (4) : There, exactly like Michael wiz sayin, like, it's the whole Dutch courage thing, like, you have a few beers ye think yer a hard man. It's not just within the younger ones. There are a lot of younger ones who're like that, but there are still some older ones as well.....

Indeed, the central features of 'being a man' were repeatedly described in terms of the relational aspects between strong physicality and men's perceived lack of emotional literacy.

Almost all of the participants agreed that it was easier for women to talk about their emotions, to express their feelings more freely, compared to men:

David (4): I'd have to say that, for some girls, they've almost got the balance right, because they're open and they're willing to talk to people but at the same time they do care about their physical appearance and how they look and how they feel about how they look. But, at the same time as that, they're still willing to go out and talk to people and say to people if you

need someone to talk to then I'm here and so on. So I mean, for like, quite a lot of girls, they've sort of got the balance almost right, I'd have to say.

Many of the participants envied the perceived camaraderie amongst women, especially in relation to their ability to talk candidly to each other about their health concerns, and women's ability to encourage each other to seek medical assistance:

Tim (2): But the support, you know, women would always speak to their friends and they would be going, encouraging her. If there was one woman who was lacking courage, and going 'I think I've got a lump on my breast', her friends would be like 'I'll go with you', but, if I try and speak to my friend, they won't be like 'c'mon, I'll go with you'!

'Health'

The apparent emphasis on the relationship between physical strength, aggression and emotional illiteracy is manifested in the ways in which participants described Scottish men's attitudes to health. Indeed, it is well documented that the requirements of hegemonic masculinity will have a negative impact on men seeking help in relation to their health (Galdas, 2009). Some participants in the homeless focus group immediately focussed their attention on the perception of Scottish men as being addicted to alcohol and drugs:

John (1): An alkie....

Tony (1): Mad wae it....(all laughs)

Facilitator: An alkie?

John (1): Hmmm...an alkie an a junkie....

Ben (1): Hard an aw. Junkies and alkies tae, cos like, maste people in Scotland take drugs an that, nah whit a mean? That's whit Scotland's aw about...(a lot of laughing from participants)...that's why a tried tae escape. A mean, that wiz me a while ago when a went tae Malaysia fur 15 month.

Facilitator: What was that like?

Ben (1): Better than Scotland. Naebody tae bother ye, man, naebody tae harass ye. Drug-free, nah whit a mean? Cos if a didnae, in sayin that, livin in Scotland, a like tae huv a puff an that, nah whit a mean? That's joost whit ye dae in Scotland, intit?

This emphasis on the centrality of alcohol to Scottish men's lives and identities permeated the discussion amongst some of the participants in the 18 -25 year old focus group:

David (4): They'll aw bring drink, they'll all drink bottles and beers and stuff and they'll all just sit around the house and drink. They don't even need to go out and drink.

Facilitator: And why do men drink?

Michael (4): A hink it's cos they've got that bravado in them.

Paul (4): It's a kind of manliness.

Some participants reflected on the ways in which there was a perception across the UK, that alcohol featured highly in stereotypical assumptions about Scottish men:

Edward (2): you know...you only have to go a 100 miles over the border and you're still tight, drink a lot, and you've...you've no got 'See you Jimmy' hair kind of thing, you know..

Some participants were keen to indicate that the conception of Scottish men as unhealthy and dependant on alcohol and drugs was not inevitable. Indeed, it is possible to escape the stereotype:

Iain (4): Am probably the unhealthiest guy in this room. Av smoked for like thirteen years and am only twenty four. A don't drink any mare, a dae exercise and it does, it gies me a good sense of well being when ye go and push yerself oot. But it's joost something that I've never been exposed tae, but it's something that am tryin tae get masel intae.

The consumption of alcohol was frowned upon by most of the members of the minority ethnic focus group, largely because drinking alcohol was forbidden through adherence to religions convention:

Bashir (3): You'll find that most of the guys around this table don't fit the bill, ye know, the stereotype of Scottish men being into drink and all that, because it's part of their religious beliefs that you don't drink, ye know?

Participants in the over 40 focus group and minority ethnic group were more likely than members of the other two groups to reflect on the significance of poor diet amongst Scottish men:

Colin (2): Poor diet. There's this view of Scots being quite poor eaters and, eh, succumbing to hear disease. It's a higher rate than the rest of the UK. I think, uh, there's often jokes made on television about the fact that the food is covered in batter and fat and, there might be a degree of truth in that.

Anwar (3): There's a real problem with being overweight in Scotland, especially in cities. Men in Scotland eat too much food that's not too good for you either.

Furthermore, as with findings in previous studies (Lanz et.al, 2001; Vart, 2010; White et.al, 2010) some participants indicated that they were resistant to seeking medical advice if they were feeling unwell. For example, one of the homeless participants indicated that:

John (1): Maste time, am like that, fuck that, pop a few pills, know whit a mean?

There was similar reticence to consult with health professionals amongst the participants in the focus group with men of Pakistani heritage, particularly amongst the older members of the group. For example:

Naveed (3): I don't go to the doctor very often. Can't remember the last time I went. You can't be seen to be going to the doctor every time you feel not yourself.

Indeed, admitting to feeling unwell, for some, was an emasculating experience and presented a direct challenge to their perceived fortitude as men:

Larry (2): Yeah, having an issue or having a health issue, could be perceived as having a weakness.

This was not, however, a sentiment that was shared by every participant:

Andy (2): If there's somehin wrong wae me, am not scared tae ask the questions about what's wrong wae me. Am strong enough tae know that, what's wrong wae me, a want it fixed. And a know the longer ye wait, the worse it's gonnae be.

Indeed, like the participants in Zanchetta et.al's (2007) study of more mature men, and Oliffe & Bottorff's (2007) study, there is evidence that most of the participants in the focus group with over 40s indicated a greater willingness to consult health professionals, and to seek out health-related information.

'The protection of others'

The emphasis on physical and emotional fortitude amongst some participants was also expressed as a form of masculine self-reliance (Connell, 2005), which manifested itself in a commitment to protecting close family members and friends from fears that participants might have about their health. Conor, one of the participants in the focus group with young homeless men, commented that:

Conor (1): A hink a lot ae guys wid be like at, try and deal wae it thersels, rather than let their loved wans know about it. So, instead o letting other people deal wae their problem, they'll just deal wae it thersels.

Facilitator: Uhuh, so they don't want to worry other people?

Conor (1): Aye, they don't want other people tae worry about it, know whit a mean? Pure bottle up in thersels again.

Participants in the focus group with men over 40 were more explicitly concerned about shielding their family from their own health concerns:

Jim (2): But also, your wife or your girlfriend or whatever, she's more likely to speak to their partner. I would be less likely to confide. I would be like 'ocht, av got a pain in my balls – it'll be fine!', you know. That's like your most loved person, and you're less likely tae open up. You know how it is....

Simon (2): You might, it might be that you don't want to unnecessarily concern them as well, and that's goin back to the, aw, we'll take it all oan wursels.....

Larry (2): If you're in a situation which mibbe affects the stereotypical position of men as the breadwinner of the family, and you don't want to affect that, cos o the implications are for those that you support.

Some participants were also concerned about the trouble that they may be causing by attending the doctor, fearing that they may be wasting her or his time, for something that may be nothing to worry about:

Tim (2): But going to the doctor's, on the rare occasion that it does happen, my opening statement is 'sorry to bother you'.

Edward (2) : And they say 'no, no, not at all – that's what we're here for'. But, that's, that's a natural sort ae....

Whilst some participants expressed their desire to protect others as a mechanism to evade consulting health professionals, others articulated this as a reason to *promote* a proactive attitude to maintaining health. For example:

Andy (2): Av got two kids, a don't want tae leave them just yet, so I want tae get something fixed and done.

Indeed, like the participants in McCaughan and McKenna's study (2010), most of the men who were in relationships with women in this study indicated that the main reason they would reveal any health concerns to their partner would be to ask for her help in seeking out health information.

4.2 Culture and Expectations

In spite of deeply entrenched depictions of hegemonic masculinity in participants' portrayals of typical Scottish masculinity, participants also stressed the importance of recognising that the meaning of masculinity was multi-dimensional and contextual (Maliski et.al, 2008; Wall & Kristjanson, 2005), and far from homogenous.

'Peers'

Participants were very clear that, in spite of the often negative stereotypical portrayal of Scottish men as physically aggressive and relatively unhealthy, the extent to which this reflected the reality of Scottish men's identities and lives was dependant upon the

environment within which men had grown up and live. For example, some of the homeless participants commented that:

John (1): It depends oan the environment ye were brought up in an that, nah whit a mean? Depends oan...the fuckin...opportunities ye get...

Facilitator: So, where you live and...

Neil (1): It's about upper class and fuckin middle class too innit?...(all laugh)*...they're aw intae it (drink and drugs) too ye know...they're aw intae it, no joost us.*

The emphasis on the influence of cultural context and the influence of peers on what it means to be a man was also evident in the talk amongst the 18-25 year old participants and participants of Pakistani heritage:

Michael (4): Pure peers, but, see peer pressure, you know, growing up wae drink, drugs, gang fightin and aw that and, if ye get away wae that then you've no really got the peer pressures, no what I mean?

David (4): The group of friends that you're with might have a different view on what it is to be a man than a group of your friend's friends, or something like that. That along with area.

Bashir (3): There's a strong influence in Asian culture, especially with older guys, that there's a real sense of social pressure to be seen to be strong and that....especially in the eyes of other men.

Peer relationships in the workplace were also identified as crucial for enhancing men's ability to address health concerns. For example, the over 40 group felt that they were lucky, because working for an emergency service organisation meant that they had access to an effective occupational health team. For them, others may be less lucky:

Jim (2): If we were on a building site, what's that chances of you getting the same conversation as this, and the same information?

'Family'

Some participants indicated that experiences, expectations and relationships within the family were integral to the ways in which they conceive of what it means to be a man:

Paul (4): Your dad, or mom, or sister or older brother. The pressure to get married or something, You kind of get the impression that you need to try to do something with your life. Um. Go to get some education, get a nice job, get a wife, kids and that will put you on the right path.

The emphasis on the strength of familial expectations on participants' sense of masculinity was particularly evident in the talk of some of the men in the minority ethnic focus group. For example:

Salim (3): Man is the head of the family. He is expected to be in control all of the time, so that his family is okay...so he can make enough money to make sure his family is okay, for his kids' future.

Positive family relationships, especially between fathers and their children, can also have a positive effect on participants' sense of self:

Andy (2): If you've got children, that makes a big difference too. I've got two teenage daughters and they have a completely different mind-set, which is a good thing, and also

Simon (2): And you're opinion means bugger all...(all laugh)...

Andy (2): There's that side ae it tae, but, they're like 'come on dad' an they try and get me into what it is now, cos society changes very, very quickly. And they, they make a big different....And a, like Simon there, ahm oan the internet aw the time and read the papers, watchin the news is one of my favourite programmes...I'm very new conscious, but still my children have brought me on a bit, cos they've got different perception. It's good, cos they've modernised their dad a wee bit...

'Age and Maturity'

A number of participants commented on how their understandings of what it means to be a man have evolved as they had grown older and, by implication, become more 'mature':

Michael (4): Cos see, even if you're goin aboot wae yer mates and they've got expectations and when ye get tae like, that age, and ye don't want tae listen tae yer mum and dad and stuff so ye always listen tae yer pals and that cos ye think they're mare important..... if ye asked me tae dae this six years ago as be like that, 'bolt ya banger', na whit a mean...(gesture with hand, everyone laughs)...a wid a been. That's cos o the people a hung aboot wae. But see since a goat rid o them, am like that, 'fuck it', a'll dae this, know what a mean, ma view's changed...

Similarly, for some, the conflation of masculinity with a hard physicality, violence and alcohol is also challenged as men grow older:

Michael (4): A hink that changes wae age as well but. If yer like at, awwwww, siging an aw that...(imitated dancing)...but like when yer younger ye want tae fight and stuff, but like when yer aulder, ye want tae like move away fae that. Dependin on yer mood.

The idea of a conception of masculinity that shifted with age was evident in the talk of participants in the focus group with men aged over 40. In this extract, unlike Michael, Tim feels that it is the 'older' generation of men who need to change, since he feels sure that younger men are more able to be open about their concerns. For example:

Tim (2): I think if there's any areas of concern, it's not with the new up-and-coming generation. I don't think there's that issue. Not the same as when we were growing up where there was a certain amount of social conditioning and expectation were required of us in the way we were brought up, which make it more difficult. Cos we're the ones that were required to change, or should change, should we see, in order to try and address some of these concerns

Tim's faith in the ability of younger men to talk openly about their feelings was well placed, particularly in relation to the views of participants in the focus group with minority ethnic men. Indeed, one of the younger participants explained how the expectations about how Scottish Asian men are expected to behave and express themselves have shifted through the generations:

Anwar (3): It's easier for us younger guys cos we can kinda talk to other folk about stuff. Av no problem wae goin tae ma doctor and that. A talk tae ma girlfriend and that...you know,

but a think it's different fur ma dad and other guys of his age. Being ill and that is kinda seen as a weakness and they've no got anybody to talk to really....ye know

However, Tim's earlier optimism about the perceived willingness of younger men to be open about their emotions and feelings is perhaps unfounded, given the apparent reticence of most of the younger participants in the study to talk freely to their friends and family.

'Societal positioning'

Participants in the focus groups with young homeless men were very clear that their homeless status had a very negative impact on their perceived status in society, particularly in relation to their chances of securing work:

Frances (1): As Kevin wiz sayin earlier, man, it's pure shite. Nuhhin's gonnae change, nah whit a mean, fuck sake man.

Facilitator: This feeling that there's nothing to do, and a lack of jobs and all that; is that something that everyone feels, do you all share that feeling of a lack of opportunities?

Ben (2): The situation's getting worse. Ye need qualifications tae get tae be a bin man. Let's go an get a joab tae be a bin man and they said ye need tae go tae college tae dae recylclin an aw that, nah whit ah mean?... Even when you go tae the army. Ye tell them yev goat a drug charge, the tell ye tae come back in 5 year. By the time 5 year comes ah'll probably huv anither couple a drug charges, nah whit a mean?....(all laugh)...

Ben continues:

B: It's hard tae get a joab wae the situation that everybody's in the noo, you know, bein homeless and that. When ye go tae try and get a joab and ye tell them ye live in a hostel, they're like that...(gestures with his hand)... they don't want tae know an aw that.

L: They luk pure disgusted.

For some participants, stereotypical associations with national identity were also considered a significant factor in how men express themselves:

Tim (2): I mean, for example, Pakistani men, like Scottish men, I suppose, we wear our pride on our sleeves. I'm not saying it's just, English and Welsh aren't as proud, but we are, really in your face. Wherever we go, and I think Pakistani men would be the same, it's our culture.

The view of a sense of pride in national identity was also highlighted by some members of the minority ethnic focus group:

Rageh (3): There are certain similarities between Scottish men and Pakistani men...sense of pride in being strong, about our culture.

In addition to national identity, some participants commented on the ways in which the area in which one lived would impact on the ways in which they might express their masculinity, as well as on their health:

Tim (2): I would say that living outside the city and working in the city, you'll find that kind of metrosexual image. You'll find that, mibbe, men who live and work in the city have, it's eh, are different no, yeah, they are probably more in touch with certain issues and can talk more freely. But I think as you move out into the more rural areas or the small towns, you definitely still have that, still, that kind of hard core, working class, we don't discuss things mentality....

Tariq (3): I would say, for sure, that where my father grew up, in the country, You were not expected to talk about health.

4.3 Conceptualising Health and Male Cancer

Participants expressed a variety of attitudes to, perceptions of and experiences of health, health care and male cancer specifically. To reiterate, key factors highlighted by participants as influential to the ways in which they considered health included degree of trust in the attitudes and knowledge of health professionals; strategies for accessing health information; knowledge about male cancers, risk behaviours and fear of the unknown; emphasising positive stories; men's propensity to ignore the signs of ill health and male cancer; and, the power of visual representations of the effects of cancer.

‘Trust’

For some participants, there was a real sense of a lack of faith in the knowledge of some health professionals, as well as scepticism about the commitment of some health professionals to get to the root of health problems. This was especially apparent in the focus group with 18 – 25 year old men:

Iain (4): Ma experience wae doctor's, for example, a personally, my brother – he wis coughin up blood for years. We're talkin three years and he went tae the doctor and the doctor telt him he wis dain it himself and a year later he went back to the doctor and was like 'I'm still coughin up blood every single mornin', the doctor said 'this is aw in your heid'. He demanded an x-ray and the doctor come in and said this is a strange question but 'have you been shot'? And, what had happened wis, he'd been punched and his filling had fell intae his stomach and it had been rippin his lung for four years and the doctor told him it wiz in his heid fur four years. And so a don't personally have any faith in the health service fae ma own personal experience.

Michael (4): The usual doctor a see is brilliant man, but aw the other doctors are like that...getting their book oot. An am like that, right, you can go into that book an turn the pages and, right, go, right, hmmm... you have breast cancer (some muffled laughter from others)... it's like, naw, haud oan a meenit, they have not got a fuckin clue man, it's joost totally, you know....

This lack of faith in the knowledge of some health professionals was evident in other focus groups. For example:

Andy (2): The doctor couldn't find oot what it was. A hud three opinions in the doctor's surgery. A went home and 'googled' it and a could see it. Lucky, and I knew what was gonnae happen. A told the doctor I found it on a New Zealand website, it was New Zealand doctors, and the doctors tried to 'google' it in front of me and they could find it. They can do that, I can do that, and I could find it and I knew exactly what it wiz, and I was correct – it's amazing.

One participant commented on the fact that it had taken 17 years to have a health issue properly diagnosed, which he found especially frustrating:

David (4): They were just sittin wae this kind of terminology dartboard somewhere, tryin tae aim at findin out what the condition was without properly knowin until I was seventeen. So, I know exactly what Michael is going on about.

Some participants were sceptical about the motivations for prescribing medications which, in their opinion, were often inappropriate and unnecessary:

Iain (4): A think nine times out of ten they're prescribing you drugs, antibiotics, just tae get a wee bit o extra money. Personally a hink that's whit happens every single time.

Whilst previous research has highlighted men's negative experiences in health care settings (McCaughan and McKenna, 2010) and their resistance to attend medical consultations (Vart, 2010; White et al., 2010), in previous research there is very little evidence of men's apparent lack of trust in health care professionals. However, the emphasis on self-reliance and physical and emotional fortitude may explain the apparent lack of trust in participants in this study, not least in terms of the necessity of revealing personal information to health care professionals during consultations, which might be considered a sign of weakness by some.

'Accessing Health Information'

Like participants in Oliffe & Bortoff's (2007) study and Zanchetta et al. (2007) study, some participants discussed potential strategies for accessing health-related information, beyond consulting with health professionals. Some were particularly concerned by the volume of 'unregulated information' that is available, especially on the internet:

Tim (2): there is a danger of that, because there is unregulated information out there. Em, I'm sitting here looking at the subject matter, and I'm thinking about the information that's currently out there, for example, breast awareness or something. There are well know and established sites now that you can go to for information. You put in 'breast cancer', and how much information you're going to get, you get millions of hits. Em, so yeah, at the moment there is that, my own personal experience, if I wanted to look for information, how would I know that I was getting the right information. And short of going to my GP, which might be right at this moment in time, the last thing that I might want to do, I might want to look at it myself, in the privacy of my own home. How do I know that I am looking at regulated information?

The need to be cautious about the potential risks of seeking out health-related information on the internet featured most highly amongst the over 40 focus group, even though this was the group which felt most comfortable employing this particular strategy:

Simon (2): The opposite spectrum is that if you start doin that it becomes quite habit-forming, and you will go mad, because if you uncover things that aren't regulated...and sometimes if you go on to these forums and people will joost post something and be like 'yes, you've definitely got this, you've definitely got that and go and see the doctor immediately', and somebody will pick up on that and be like 'oh my god'...

Andy (2): You've got tae watch that, you've got tae watch that...some crank will tell ye somehin, and you've got tae be very, very careful.

For some, however, the benefits of accessing information via the internet outweigh the potential risks:

Andy (2): Av looked at things and thought, you know, even for health issues of friends.....one of my best friend's wife's got breast cancer in both breasts. I thought 'that's terrible' and I went and 'googled' it and, by and large it wasn't as bad – I thought because it was two, it would be twice as bad, but this necessarily wasn't the case and I found that reassuring just to know that.

Not all participants felt confident about knowing where to look for information about men's health and well being. Some participants indicated that they felt there was a lack sources of information for men specifically, and that it was important to have a physical place, as opposed to a virtual space, for men to go to access information about health:

Anwar (3): I don't know where to look. You know, there's lots of informations for women....breast cancer, other cancer for women...but we have nowhere to go and get advice. I think the idea of having place to go for information for men is great....we need that .I don't think internet is ideal. I would prefer to be able to go to a place and pick up information if I need it, talk to someone if I need to...that's why places like this are so great.

Here, Anwar is referring to a community space that is accessed by other Asian men, in which they can attend talks or meetings or access advice on a range of issues with other

Asian men. Given previous evidence that men are more likely to feel uncomfortable in health care settings, less likely than women to seek out health care information and less likely than women to attend for treatment (Vart et.al, 2010; White et.al, 2010), there is evidently a need to create spaces and places (real and virtual) where men can feel safe to talk about their health concerns generally, and male cancers specifically. When men are given the space and time to talk to other people like themselves, there is evidence of increased willingness to seek out health information (Oliffe & Bottorff, 2007).

‘Impressions of cancer, risk and fear of the unknown’

A diversity of responses were offered when participants were asked to say a few words which described how they understood cancer, which largely focussed on perceptions of the inevitability of death, male genitalia, fear and uncertainty:

Neil (1): That am dyin

Ryan (4): Death

John (1): Testicles

Michael (4): Ma balls

Ben (1): Shock

Yousuff (3): What’s going to happen to me?

Malcolm (4) What does it mean?

Nicolas (4): Fear

Clive (4): The way you live and eat

Some participants commented on the uncertainties surrounding cancer, not least in terms of the ways in which apparently ‘healthy’ people could develop cancer, as well as the possibility of cancer returning even if an individual had beaten cancer:

Ben (1): Aye. See when folk get cancer, a mean, maste ae them don’t even smoke, it’s mad innit? A mean, ma granda died ae cancer and he’d never smoked a fag in his life.

Neil (1): Aye, a mean. Even if you've got rid of it, you've always got that fear of it comin back again, haven't ye?

The prospect of developing prostate cancer was an especially frightening prospect for some participants, especially having seen the effects that prostate cancer had on Patrick's quality of life detailed in the vignette adapted from Oliffe and Bottorff's (2007) paper:

Ryan (4): You'd rather just die than have your prostate removed.

David (4): It affects a lot more than just, like just the thing itself, it affects the family, affects your work, affects your self-esteem – everything.

Ben (1): It's a pure shocker innit

Even when men are aware of the relationship between certain behaviours and an elevated risk of developing cancer, this did not guarantee that such awareness would result in behaviour change or leading a healthier lifestyle:

Iain (4): A hink the problem is makin people aware of what the dangers are, eh? And then if people know the dangers and they still want tae drink a bottle a vodka, that's their choice.

Clive (4): Ye can tell someone that ten pints is gonnae gie them cancer. They're still gonnae go tae the next pint.

'Positive Stories/Positivity'

Participants were keen to focus on positive stories, relating the positive experiences of people they had known who had beaten cancer.

William (1): See ma gran...ma gran fun oot she had cancer aboot two month ago, or somehin. And two weeks ago, she goat a lump removed cos she's goat breast cancer. And she has tae go back tae get sumhin else done, but it's amazing whit they can dae, intit?

Ben (1): It's some skill, innit? How they can get rid o cancer. It's fuckin amazin...

Ryan (4): Doctors, nurses, to an extent do an amazing job.

And in relation to Patrick's recovery from prostate cancer, some participants commented that the centrality of his own positive attitude was key to his recovery:

Iain (4): His positivity as well is like, a key factor, if he hadn't been positive about it.

David (4): See, it's not just about the physical recovery form it. It's the mental side too.

'Misconceptions'

Given the evidence that some men appear to be unwilling to seek out information on health generally and male cancers specifically (McCaughan and McKenna, 2010), it is unsurprising that some participants were unclear on which particular cancers could affect men only:

John (1): Whit? Can burds no get prostate cancer, naw? How?

And, in another group:

Facilitator: So, what about male cancers? How many specifically male cancers do you think there are?

Ryan (4): Bowel and prostate are the most common.

And in another exchange between participants in the focus group with homeless men:

Facilitator: So, do you know of any cancers that only men can get?

(The group are able to identify testicular and prostate cancer)

Victor (1): Colorectal cancer, up the arse an that....

Tony (1): Naw, luk, burds can get that tae. It says it oan the presentation.

Facilitator: Actually, the other specifically male cancer is penile cancer.

Ben (1): That's pure mad man, innit? A didnae ken ye could get cancer oan yer cock. Fuck sake.

Facilitator No, actually, neither did I until I started reading about all of this.

'Ignoring the signs'

Like the participants in Dubé et.al's (2004) study and White et.al's (2010) study, there was recognition amongst some participants that men are more likely than women to ignore the signs of ill health and attend for treatment. For example, one participant in the 18 – 25 year old focus group reflected on his friend's attitude:

Paul (4): A lot of his family have got a lot ae problems wae mental health and that and they don't really see that as, like, a problem, they just kind of see it as a kind of, they just kick it under the carpet and they just leave it until the very last minute when they have to go intae hospital or something ... when it comes tae his emotions, he won't bother with that at all, he'll literally kick it under the carpet.

Some participants said that it was likely that most Scottish men would ignore the signs of cancer:

Victor (1): A lot o guys just get on wae it, know what a mean, they're like at, 'fuck it', let's say, you know, it's joost a Scottish hing, know whit a mean, you know, we're gonnae ignore it, int we?

Jim (2): But others, other men, which is problem for Scottish mean, in taking that first step, just to take it. Oh, I'll go, but I'm pretty sure it's aw right and, they'll go, 'aw, it's nuh hin'. And it gets sorer and they're thinking, 'aw, it's nuh hin, it'll go away'. And when it is really serious and ye get taken away in an ambulance and, then, by that time it's too late.

White et. al (2010) advocated a more aggressive approach to treatment. However, according to most of the participants of the participants in this study, this would only be possible if there was greater awareness about men's cancers generally, in order to encourage men to take the risks and signs of cancer seriously:

Tim (2): Yeah, but it's encouraging men, and it's to give us, generically, the confidence to come forward.

‘The visual currency of cancer’

Some participants commented that, whilst they did not think about cancer on a regular basis, visual images of the effects of cancer did or would force them to reflect on the implications of their lifestyles and behaviours:

Ryan (4): Sounds kind of sad really, but the only time I only really recognise that cancer's there is when I go and buy fags, so....

Facilitator: What makes you think about it when you buy fags?

Ryan (4): Just seein like a guy, wae the pictures on the packet.....

For Tim, advertising on television could have just as powerful an effect than graphic depictions of the effects of cancer on cigarette packets:

Tim (2): . I think, in my personal, well my personal thoughts are that we just need a constant reminder that, a visual stimuli, as you do get on the TV, advertising. I keep on saying the breast cancer thing, but you know, something similar for men. I know that needs resources.

Some participants commented, however, that it was important not to overplay the impact of visual images of the effects of cancer, especially those on cigarette packets:

David (4): Images, like on the cigarette packet, it's every day. You watch a horror movie one time, you're scared. You watch it a few times, that's it, you're not scared any more.

Michael (4): It's like collecting the fitba cairds wae they cigarette packets. Whit picture huv ye goat the day?

David (4): It's ironic as well, that they still put them on cigarette packets. A mean, I know it's supposed to put them off, but the only real way to see these pictures is to but them anyway and you're not gonnae buy a packet of cigarettes only to go 'oh that's hideous'.

4.3 Humour

Hilton et.al (2010) and Chapple and Ziebland (2004) examined the ways in which men will use humour to deflect attention from their anxieties and embarrassment surrounding health generally, and cancer specifically. Indeed, participants in this study often employed humour

when discussing cancer, either to diffuse a situation in which a very serious issue was being discussed, or to ridicule other participants when they were unsure about something:

John (1): Where is yer prostate? Is it up yer arse?

Facilitator: Yeah.

John (1): For fuck sake man...(all laugh heartily)...

Victor (1): Ha ha ha – you’ve goat a pure beamer John!

In the instance below, humour was also employed when the participant was trying to account for the apparent blasé attitude of some medical professionals towards the health of patients:

Ryan (4) My next door neighbour actually works for the NHS, and she’s told me some amazing phone calls she’s had, you know this guy phones up and says, ‘oh I’ve got some purple stuff coming out ma belly button’. Sounds messed up and she was like, ‘what colour is your t-shirt’ and he was like ‘aw purple’...(everyone laughs)... seriously, this guy ate four socks, I mean, you deserve to die if you eat four socks. It’s ridiculous. No wonder doctors are just like oblivious to stuff and are like, aw right, whatever, here take that’. You know, they’ve probably gone into the job thinking aw, what tards am a gonnae meet today?

When participants were asked to reflect on how Scottish men would react to Patrick’s experiences of prostate cancer and his photograph of the urine pad, some participants commented:

John (1): They’d probably laugh at it, man.

Facilitator: Why would they laugh?

John (1): Dunno, cos it’s a pure riddy man....it’s joost wur sense o humour innit, it’s pure fucked up.

Furthermore, when the facilitator indicated that demonstrations with real men offering explicit advice, demonstrating testicular self-examination were available on a variety of sources on the internet, some participants reacted with humour:

Facilitator: Actually, if you go onto John Hartson’s charity’s web site, there a video demonstrating how men should check their balls.

(All laugh heartily)

W: For fuck sake man, ha ha ha.

Humour has been identified in previous studies as a mechanism for ‘dealing’ with health issues or managing assumptions in personal relationships (Chapple and Ziebland, 2004; Hilton et.al, 2010). However, the deployment of humour was especially apparent amongst the younger participants in this study when discussing the ways in which the threat of cancer challenges the embodiment of masculinity, not least in terms of feeling pressured to know where particular parts of the male anatomy were located, or being knowledgeable about the practicalities of procedures like testicular self-examination.

4.5 The Power of Personal Narratives

In contradistinction to research which reported that masculinity can often be a barrier to men talking about, and seeking help for concerns about their health (Galdas, 2009; McCaughan and McKenna, 2010), there is evidence from this study to suggest that men are, indeed, able to talk about their emotions, health, well being and fears about male cancer specifically, when they are provided with the opportunity to do so with other men like themselves. Indeed, Oliffe and Bottorff (2007) have argued that men do talk in their own cultural environs, and participants in this study reacted positively, and empathetically, to hearing about stories of other men who had been diagnosed with, and recovered from cancer. Indeed, there was a unanimous, overarching and deep sense of empathy amongst all of the participants for other men who had experienced cancer, particularly the two men described in the vignettes. For example, when asked if Patrick’s story would encourage other men to attend for prostate screening:

Ben (1): Definitely, man, especially, y’know, if the guy’s runnin aboot wae a pure fuckin nappy oan, nah whit a mean? Ad hate tae pure huv wan ae them oan the noo man.

Facilitator: So you think Scottish men might be a bit, you know, taken aback when they hear about Patrick’s story?

Ben (1): Shocked man, pure shocked.

Iain felt the photograph of Patrick was effective in catching the attention of participants, but that the photograph was even more powerful when accompanied by Patrick's story, in his own words:

Iain (4): A hink cos it was a story behind that. If we'd joost seen that we wudnae really huv known.

This was a view shared by Simon in the over 40s group, and Naveed in the minority ethnic focus group, when reflecting on the powerful effect that Patrick's story is likely to have on men:

Simon (2): But I think it's designed to do that, and if it didn't have the back up the text, giving the guy's experience, then it would remain a shocking image. But, what it's done, it's sucked you right in. We've all seen this image, and we'll sat and took a deep breath and though 'what is the outcome for this guy?', but you know what? It's a necessary evil to wear that thing, it's alright to do that.

Naveed (3): Other men would react with shock when they see that photo. Not knowing what can happen to you when you get the prostate....if men can know that this will happen, then they will sit up and listen, won't they?

And in relation to the experiences of John Hartson, participants were similarly empathetic:

Facilitator: And he says that he ignored the lump that was developing in his testicle....(inaudible)...so do you think that this would be a common thing for men to do?

Neil (1): Aye, definitely, because you'd be pure disturbed by it, but, you'd be like, aye, I'll just leave it and it'll be alright, you know?

Nicolas (4): People like John Hartson, shows like anyone can get cancer. And hearing him is more effective than putting them pictures on cigarette packets. If Scottish people will see John Hartson having cancer, they will get themselves checked out.

Some participants were especially open and honest when describing the experiences of people they knew personally:

Iain (4): Ma pal's dad died o lung cancer and he saw him every day for three years wae his jaw wired shut and he couldnae eat. And he hud tae eat through a tube and he's like, he still smokes. And he showed me some ae his note books and that's a billion times mare powerful than they images..... he knows it bad for him, but he still smokes.

Clive (4): It's insanity.

Ryan (4): It's no insanity, it's just addiction.

The emphasis on the power of personal narratives was not exclusively focussed on the experiences of the characters in the vignettes or people who the participants knew. Some participants were keen to express their own personal experiences of having had a cancer scare or, indeed, having been diagnosed with cancer. Michael feels that health professionals need to be more sympathetic to men when they attend for a consultation:

Michael (4): Cos, see six years ago, a fun a lump and the doctor sent me tae the hospital, right, and a wiz up oan the bed wae ma bits oot an the guy wiz like 'aw did ye watch this oan the telly and that' and 'aye it wiz brilliant' an aw that, but av never felt so humiliated. It wiz just like, a didane even huv their attention, it wiz joost like, jump up, whoop, bang, we'll see ye later and a wiz like 'haud oan a minute, man, am sittin here shittin masel and your hinkin it's like wan o the maste worrying things.

David (4): It's one of the most worrying things ever, but for doctors and nurses, it's almost too every day for them.

Michael (4): A didnae get any respect. A wiz joost treated as a bit o meat, know what a mean, like a wiz at a butcher.

Participants also listened attentively when Andy revealed that he had survived testicular cancer to the other members of the over 40s focus group:

Andy (2): Okay, I'll own up, I had testicular cancer. I kept on pushing it with my doctor and he was saying there's nothing wrong with me and I kept on pushing for ages and it was only by luck that I pushed myself. So, in other words, I bypassed my GP and went back to, I ended up getting a scan. But because I did it myself, because I was in pain, he put me back to the consultant, who seen me, and a day later, it turned up cancer. But a wiz, I pushed masel. I know other people who've hud testicular cancer, been with them, and they are typical, stereotype. They're scared and kept it to themselves, and things like that, and as a result, for them the cancer was worse. I wiz lucky, well, 11 months later I had to get chemotherapy, but it didn't spread anywhere else, in other organs, weren't affected. But a wiz kinda, kinda lucky.

Whilst Mc Caughan and McKenna (2010) argued that the participants in their study were unlikely to adopt proactive strategies for access information following a cancer diagnosis, Andy is especially keen to emphasise the ways in which he adopted a proactive strategy, acting on his instinct that all was not well. Andy's tenacity did not go unnoticed by the other members of the group:

Jim (2): If you make the first step, like Andy did, and speak to the doctor and they're like, 'nah, nah, you're fine', it's nuh-hin, but ye keep on pushin, ye get good outcomes.

'Reconfiguring Identity'

There is ample evidence that portrays the ways in which the experience of cancer can have a dramatic effect on men's sense of masculine self (Kelly, 2009; Maliski et.al, 2008; Oliffe & Bottorff, 2008). More generally, there was evidence that some participants were sympathetic to Patrick's story, in particular, because of the effects that prostate cancer had on his everyday life and, more specifically, the modifications that Patrick was required to make to lead an everyday life:

David (4): It's a major self-esteem issue. Like, even when he's at work and, like, got like whatever, whether it's a work suit or, like jeans, or whatever, it's like, even if that's covering the pad, he still knows he's wearin the pad and that could be a self-esteem issue for him as well. Because he could be goin about the place and, you know, he could be sitting worrying and like, 'what if this leaks' and 'what if I stand up from my desk and people see that I've just wet myself?' in the middle of work.

However, like the survivors of cancer in the studies by Maliski et. al (2008) and Kelly (2009), some participants were more explicitly concerned by the impact that the experience of prostate cancer will have had on Patrick's masculinity:

Larry (2): I think. Obviously, there's an impact on the way that he's feeling and about his masculinity, balance that against his mortality. We need exposure for men, mainstreaming these issues, is one way of breaking down these barriers of masculinity.

Indeed, Jim, Simon and Larry all speculated on the potential impact the experience of prostate cancer might have on their own sense of masculinity:

Jim (2): My immediate feeling was, I don't want that to happen to me, on an emotional level, and on a masculinity level.

Simon (2): I think the emotional thing is a pretty good point, but I think, I'd imagine that if you're faced with your own mortality, you would quite quickly get over your masculinity issues. It's a balance.

Larry (2): What am stressing is that your masculinity is the barrier, probably the biggest barrier that you need to get over to get to that stage.

Some participants drew attention to the ways in which the absorbent pad which Patrick had to wear resembled a child's nappy, and reflected on the impact that this might have on his identity, as Patrick had himself in Oliffe and Bottorff's (2007) study:

T: It must have been quite difficult because, psychologically, I suppose, you're now...you, you...em...relate the wearing of a nappy, or some sort of pad like that to children when they're unable to control themselves, and that lack of self-control, and maybe older people, eh, in their 90s and so on. And for him to have to wear something like that, as a by-product and as a result of going through what he had to go through, em, it must have been quite difficult

It was inconceivable to some participants, that they would have the strength to tell their story in the frank and transparent way that Patrick had and, for that, they had the utmost respect for him:

Michael (4): A take ma hat aff tae oanybody that's come through somehin like that an come oot, cos, sittin here and, naw, a don't know if a could dae that.

David (4): You know, havin the bravery to discuss this and use himself as an example for others and sayin, look, this is what I've went through, this is how I dealt with it and this is what I was feeling at the same time. A mean, personally, if it was me, I'm struggling right now to be able to see if I would be confident enough to be able to talk about it afterwards. If it wiz me, a would probably be like, 'it's happened, it wiznae good, a don't want tae talk aboot it', but he's had the courage in himself tae discuss it and that and, you know, let himself others by talking about what's happened.

Anwar (3): He is a very, very brave man. You have to express a lot of admiration for him. To show his body like that was a very brave thing to do.

As is evident above, whilst the participants in this study indicated that men, in general, are reticent about talking about their emotions and health, men can and do talk to each other about health in general, and cancer specifically, especially when they are confronted with real stories about real men. The power of real personal narratives of men who had been diagnosed with cancer should not be underestimated as an effective tool for encouraging men to think about the perceived benefits of regular health checks and male cancer screening.

5. Conclusion and Recommendations

To recapitulate, the aim of this small-scale project was to explore Scottish men's awareness of 'male cancer' specifically and to examine the relationship between the lived experience of masculinities and the meanings that men attribute to health and well being, health care providers and services and male cancers. More specifically, the research addressed the following questions:

- What does being a man living in Scotland mean to participants?
- What do Scottish men understand 'male cancer' to mean?
- Does being a man impact on awareness of specific cancers, cancer risks and cancer screening services?
- What are the most effective means of raising men's awareness of male cancers?

The hegemonic ideals of power, strength, self-reliance and emotional fortitude permeate the generalised conceptions of masculinity portrayed by the men living in Scotland who participated in this study. However, such generalised conceptions of hegemonic masculinity did not necessarily reflect the reality of men's everyday lives, and participants emphasised the need to recognise that being a man is entirely contextual, contingent upon time, place and cultural contexts, such as family relations, peer relations, national identities and age; in other words, masculinity manifests itself in many ways. Notwithstanding some participants' desire to separate themselves off from stereotypical portrayals of hegemonic masculinity in Scottish men, some traits still persist in this small sample of men: most participants felt uneasy about being open about their fears in relation to health and well being generally, and cancer specifically, not least because of a desire to protect those people that they care about most; and, nearly every participant recognised the explicit threat that cancer posed to the hard physicality of the embodiment of masculinity. The central components of masculinity

and maleness are still exemplified in the relationship between physical strength and emotional fortitude amongst the participants in this study.

Participants' attitudes to health and well being were varied. Most participants expressed, at some point, some dubiety in relation to their faith in the attitudes and knowledge of health care professionals, often relaying personal experiences of anxiety, embarrassment, frustration and, at times, delayed diagnosis to justify their scepticism. As a corollary to this, participants would also occasionally share their positive experiences in health care settings and, more often, relate the positive experiences of people they knew. Whilst a proactive approach to maintaining health and well being was not a main feature of the experiences of most participants (although there were a few isolated 'champions' of adopting a proactive approach), there was a widespread recognition of the need to take health seriously but this was dependant on: knowing where to look, or who to ask, for advice about men's health issues in particular; being prompted by others to seek medical assistance; avoiding undue anxiety and embarrassment if at all possible, and this was certainly the case in participants' discussions about male cancers.

Participants were able to identify testicular and prostate cancers as specifically male cancers, but were less knowledgeable about the existence of penile cancer. Participants recognised that it was likely that men would ignore the signs of cancer, even if they were aware of the common symptoms. They also indicated that men would be more likely than women to delay seeking medical consultation and treatment. Participants explained this in terms of the ability of women to share their fears about their health with other women, as well as increased awareness and heightened visibility about women's cancers (such as breast cancer). By contrast, men did not have the same ability to talk to each other about their concerns, nor was there a high degree of awareness of the signs of cancer amongst the participants, and there was a perception of a lack of readily available information about male cancers.

Most participants in this study indicated that they found it difficult to talk about their feelings in relation to health and well being. Some groups drew attention to the assumptions that people might make about their identity as a potential barrier to opening up (for example, the young homeless men felt that their 'homeless' label meant that people would not be interested in listening to their concerns), and some groups identified attitudes within their own communities as barriers to opening up (for example, the older Asian participants highlighted the need to maintain a sense of stoicism for the sake of their families, and some of the younger participants indicated a peer pressure to 'bottle things up' and continue partying).

However, in spite of the perceived barriers to men speaking frankly about their emotions, and the expectations of maintaining masculinity, the participants in this study were, in fact, very effective during the focus groups at opening up about their feelings about being a man and their attitudes to health, well being and male cancer. It was evident that participants, by and large, felt comfortable to talk to other men who were like themselves, who share common experiences, hopes and fears. Participants want to know more about male cancers, if only they knew who to ask or where to look for advice and knowledge.

The most striking feature of the data generated from the focus groups lies in the dynamic, emotional, positive and proactive way that participants reacted to the personal narratives of real men who had been diagnosed with and had beaten cancer. Visual depictions of men's experiences of cancer, supported by subjective narratives, provided participants with the confidence to reflect on their own identities as men, and experiences and fears about health generally, and cancer specifically.

In light of the narratives of this small sample of men living Scotland, the following recommendations are offered:

- There is a need to recognise the particular experiences of particular groups of men living in Scotland, and the resultant potential cultural barriers, when devising public health information on male cancers specifically.
- There is a need to increase men's awareness and knowledge of the causes of male cancers, risk behaviours associated with male cancers, the symptoms of male cancers and the procedures for diagnosing and treating male cancers.
- The creation of safe places and spaces (real and virtual) for men living in Scotland to access information about male cancers.
- The development of sources of information on male cancer that are specifically embedded in the photographic, spoken and written expressions of the real-world experiences of men living in Scotland who have been diagnosed with, and survived, cancer.

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Appendix One: Focus Group Guide

Identity

- Who are you? How would you describe yourself?
- What does being a man mean to you?
- What would you say are the typical characteristics of being a man?

Health

- What does being healthy mean to you?
- How important is keeping healthy to you in your day-to-day lives?
- Do you feel comfortable talking to other people about issues related to your health?
- Do you think that being a man impacts on who you can/want to talk to about your health?
- In your opinion, is it different for women?
- Can you tell us a little bit about your attitudes to health care providers? Do you have any experiences of health care that you'd like to share with the group?
- Who do you talk to, if anyone, about your health? Who do you go to for advice about keeping healthy?

Cancer

- As you know, this project is designed to find out what men think about male cancers. What words spring to mind when you think about 'cancer'? Please write the words on post-it notes.

Vignette

Participants will be shown the photograph below, before the researcher reads aloud the vignette below.



Source: Oliffe, J & Bottorff, J. (2007) 'Further Than the Eye Can See? Photo Elicitation and Research With Men', *Qualitative Health Research*, 17: 850.

Patrick asked his wife to take pictures of him in their kitchen to illustrate how his body had changed after his prostatectomy. This photograph demonstrates the application of an absorbent pad that collected urine, which leaked sporadically for 3 months following surgery. Patrick explained how he had remained optimistic and "looked for improvement every day" as he described what the absorbent pads were like: "I started off with a bigger one than that. It was more like a nappy but after a while I got to those and they were fine, just a little pouch and I was able to use these for another month or so after I went back to work". Patrick returned to work while still wearing the pad. Eventually, Patrick regained control of his bladder, and throughout his slow and steady recovery, he recalled, "I didn't doubt that I would recover [continence] and I was always positive."

Vignette questions for discussion:

- How effective is this photograph for telling us about how Patrick feels following his surgery for prostate cancer?
- What do you think men would make of Patrick's photograph and story?
- Do you think that men would feel sympathy for Patrick? If so, why? If not, why not?

- Do you think that men would consider Patrick to be brave to tell his story in this way?
- What can men learn about prostate cancer from Patrick's photograph and story?
- Do you think Patrick's story might help other men to talk about prostate cancer?

Participants will be shown a video interview with John Hartson, a well known former footballer who is currently battling cancer. The video can be accessed here:

- <http://www.youtube.com/watch?v=ewzIEFx0sPQ>

Questions for discussion:

- How would you describe John Hartson?
- Were you aware that John Hartson had been diagnosed with cancer?
- John Hartson says he ignored the signs of cancer. Do you think that this would be common amongst men in Scotland?
- Why do you think he might have ignored the signs of cancer?
- How do you think men in Scotland reacted when they heard that John Hartson had cancer?

Appendix 2: Information Sheet



Research Title: Men, masculinities and male cancer awareness in Scotland: a preliminary study

What is the research study about?

My name is John Hughes and I am conducting research on behalf of Cahonas Scotland, a new charity which has been set up to improve awareness of male cancers.

The aim of this research study is to try and understand Scottish men's knowledge about male cancers and cancer screening strategies.

What is my role as a participant?

I am inviting you to take part in a focus group with some other men, during which we will talk about people's understanding of male cancers and cancer screening services. I will also talk to the group about some simple case studies about male cancer generally to help us with our discussions.

This will take place in at X on X. The focus group will last no longer than 1 hour, and will be tape recorded with your consent.

The main aim of the study is to gain a deeper understanding of what a range of men living in Scotland think about male cancer and how we can raise awareness of male cancer across Scotland.

Your participation is purely voluntary and you can withdraw from the study at any time without giving any explanation.

What will happen to the information I give?

The information gathered from the focus group will be transcribed and all personal details relating to your participation will be treated in the strictest confidence.

Every effort will be made to ensure complete anonymity.

Anonymised extracts of participants' verbal contributions will form part of a presentation which Cahanas Scotland will use to help in the development of strategies for raising awareness about male cancer.

Further information:

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Cahonas Scotland is a Registered Scottish Charity SC040786

Appendix Two: Consent Form



Research Study Consent Form

Title of the project: Men, masculinities and male cancer awareness in Scotland: a preliminary study

Researcher: John Hughes on behalf of Cahonas Scotland

I confirm that I have read and understood the information sheet for the above study, and I have had the opportunity to ask questions.	
I understand that my participation is voluntary and that I am free at any time to withdraw at any time, without giving a reason, without my legal rights being affected.	
I agree to the focus group being tape recorded, which will then be transcribed by John Hughes .	
I understand that all information or any personal details collected will be treated in confidence and will be anonymised	
I understand that the information I provide will be used in writing the report of this research study.	
I agree to participate in this study.	

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Name of participant:

Signature of participant:

Date:

Researcher's signature: